

CERTIFICATE OF DEATH

Reg. Dist. No. 11466

11481

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond				c. LENGTH OF STAY IN 1b 75 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle P. Last Atwell				4. DATE OF DEATH Month October Day 8 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1879	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor				10b. KIND OF BUSINESS OR INDUSTRY Medical		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME George W. Atwell				14. MOTHER'S MAIDEN NAME Abigail Daniels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Bertha C. Atwell		Address Still Pond, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis, e auricular fibrillation DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-2 , 19 61 , to 10-8 , 19 61 , that I last saw the deceased alive on 10-7- , 19 61 , and that death occurred at 2:15 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10-9-61							
ACTUAL SIGNATURE A.C. Dick				M.D.			
PHYSICIAN'S NAME (Type) A.C. Dick, M.B.				Chestertown, Maryland			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 10/10/61		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy				ADDRESS Still Pond, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. House	
24a. REC'D BY REGISTRAR DATE OCT 10 '61							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11482

11467

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write Chestertown and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write Chestertown and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Heights				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William E. Middle Davis Last				4. DATE OF DEATH Month Oct Day 19 Year 1961			
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2 1883		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming		10b. KIND OF BUSINESS OR INDUSTRY grain		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Davis				14. MOTHER'S MAIDEN NAME Emily Jane Madaway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Wm. E. Davis Address Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 42011 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Felony						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-3 1957 to 10-18 , 19 61 , that (I) (we) last saw the deceased alive on 10-2 , 19 61 , and that death occurred at 5:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE A.C. Dick				22b. ADDRESS Chestertown, Md.		22c. PHYSICIAN'S NAME (Type) A.C. Dick	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 21/61		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvin V. Williams ADDRESS Chestertown Md.				25a. REC'D BY REGISTRAR OCT 23 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

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Official of Health

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11483

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11468

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leon Middle Owen Last Donnelly			4. DATE OF DEATH Month Oct. Day 15 Year 19 61				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1914	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 47 Days 15		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Howard Donnelly			14. MOTHER'S MAIDEN NAME Mary Cannan				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-14-2793		17. INFORMANT Address Mrs. Mary Donnelly-Rock Hall, md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Norbert C. Nitsch		M.D. Norbert C. Nitsch		DATE SIGNED Oct 17/61			
EXAMINER'S NAME (Type) Norbert C. Nitsch		Address (Street, city, town, or county) Rock Hall, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 18	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel	22d. LOCATION (City, town, or country) (State) Rock Hall, Maryland				
23. FUNERAL DIRECTOR Edgar L. Kane		ADDRESS Church Hill, Maryland		24a. REC'D BY REGISTRAR OCT 26 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Hume		

MEDICAL CERTIFICATION

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11484											
11469											
1. PLACE OF DEATH a. COUNTY Kent						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown						c. LENGTH OF STAY IN 1b 17 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital						d. STREET ADDRESS Rural Rock Hall, RFD#2					
3. NAME OF DECEASED (Type or print) First Revington Middle Lyman Last Embree						4. DATE OF DEATH Month 10 Day 19 Year 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/18/93		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher						10b. KIND OF BUSINESS OR INDUSTRY New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert Lyman						14. MOTHER'S MAIDEN NAME Nettie E. Ziegler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						17. INFORMANT Address Revington L. Embree, Patient.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction due to coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerotic cardiovascular disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 17 days 8 yrs											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 10-2- p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (the hospital) attended the deceased from 10-2- 19.61 to 10-19- 19.61 that (I) (we) last saw the deceased alive on 10-2- 19.61 , and that death occurred at 7:30am from the causes and on the date stated above.											
22a. SIGNATURE Harry B. Ross M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-19-61			
22c. PHYSICIAN'S NAME (Type) Harry B. Ross, M.D.						22d. ADDRESS Chestertown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 21		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town or county) (State) Rock Hall Ind.					
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane						25a. REC'D BY REGISTRAR Oct 24 '61		25b. REGISTRAR'S SIGNATURE William S. Thomas			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11485 CERTIFICATE OF DEATH 11470											
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Queen St. (At Home)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS Queen St. #202 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Sophie Beck Fisher						4. DATE OF DEATH Oct. 10, 1961					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 5, 1881		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James L. Beck						14. MOTHER'S MAIDEN NAME Elverta Brice					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Bertie Nicholson Address Chestertown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes.										INTERVAL BETWEEN ONSET AND DEATH 3 months 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 18, 1961 to 10-10-61 , that (I) (we) last saw the deceased alive on 9-26-61 , and that death occurred at 1 a.m. from the causes and on the date stated above.											
22a. SIGNATURE A.C. Dick, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10-11-61		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) A.C. Dick, M.D.						22d. ADDRESS Chestertown, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/12/61		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery			23d. LOCATION (City, town or county) near Chestertown, Md.			(State)
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells						ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR OCT 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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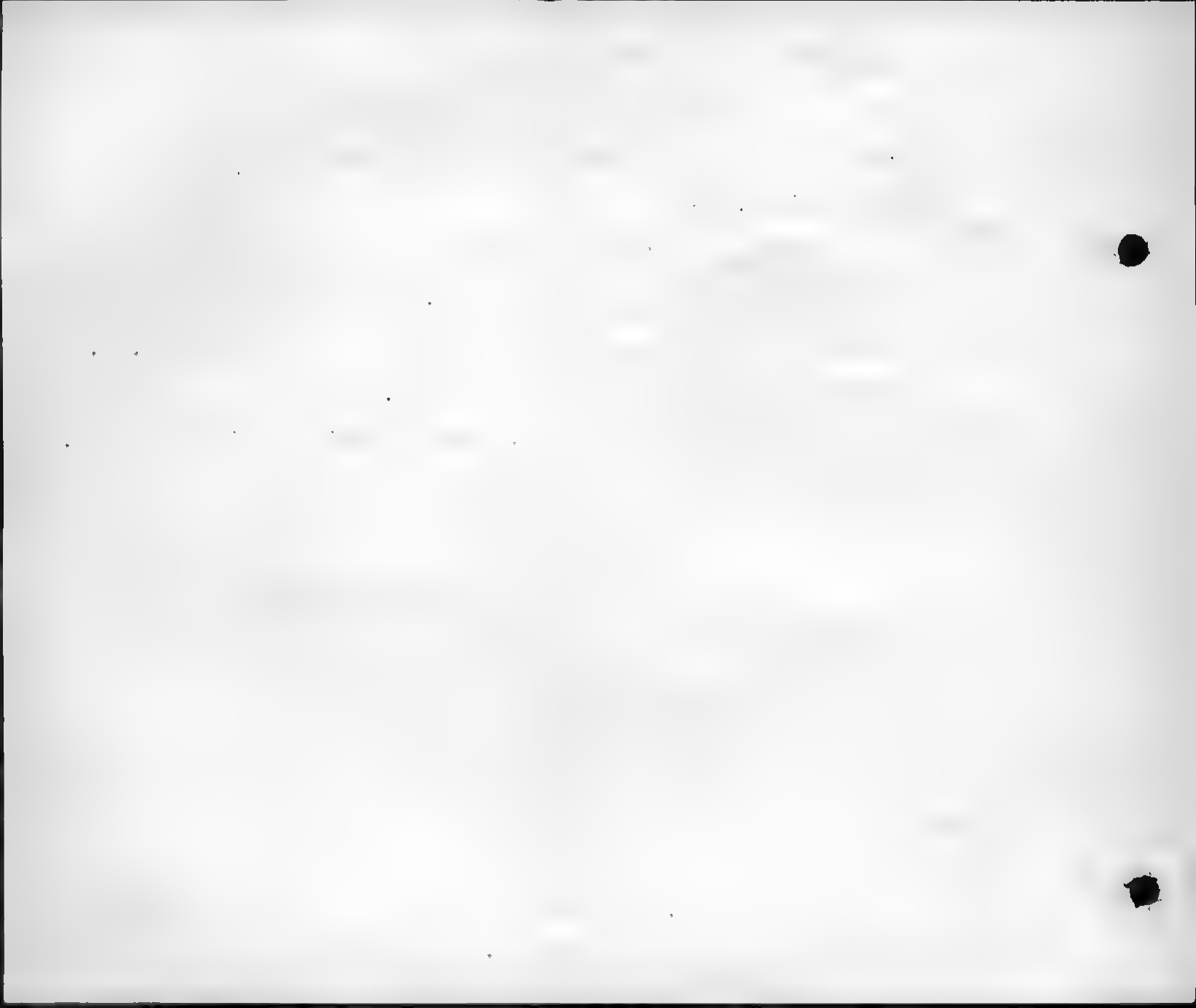
11486

CERTIFICATE OF DEATH

Reg. Dist. No.

11471

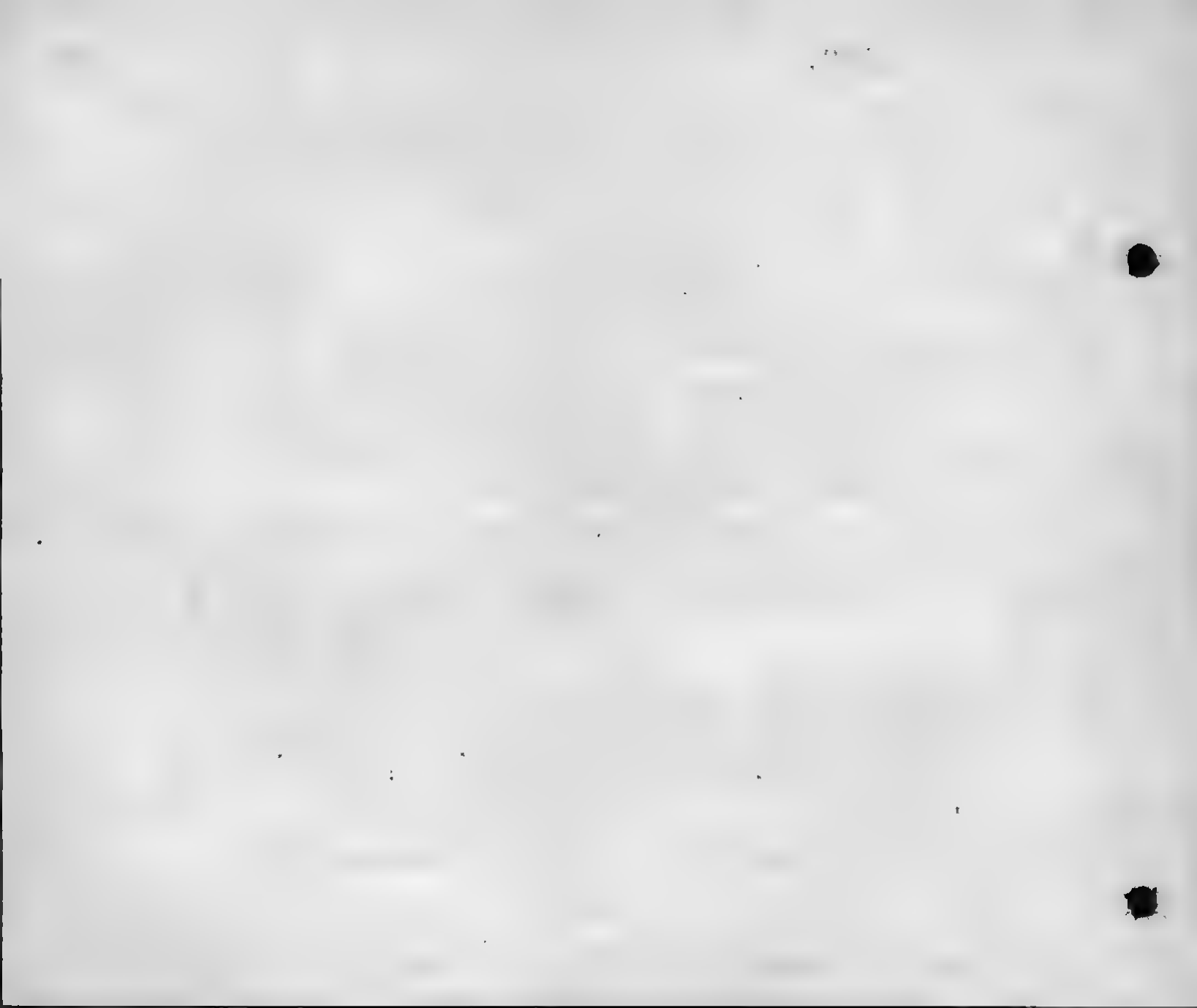
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairlee c. LENGTH OF STAY IN 1b 1 Year d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Strong Nursing Home				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond d. STREET ADDRESS 1 --- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle Price Last Hepbrson				4. DATE OF DEATH Month October Day 18 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1880	
9. AGE (In years last birthday) 80		10. UNDER 1 YEAR Months 80 Days 80 Hours 80 Min 80		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles H. Price				14. MOTHER'S MAIDEN NAME Mary C. Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Carson Harris		Address Still Pond, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 444X DUE TO Smelly Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertension DUE TO (c) 15 years							INTERVAL BETWEEN ONSET AND DEATH 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-21 , 19 61 , to 10-18 , 19 61 , that I last saw the deceased alive on 10-14 , 19 61 , and that death occurred at 1 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 10-18-61							
ACTUAL SIGNATURE A. C. Dick		M.D. A. C. Dick		PHYSICIAN'S NAME (Type) A. C. Dick		LOCATION (City, town, or county) (State) Chestertown, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/61		22c. NAME OF CEMETERY OR CREMATORY I. U. Cemetery		22d. LOCATION (City, town, or county) (State) Worton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Victor M. Kennedy		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR OCT 20 '61		24b. REGISTRAR'S SIGNATURE Charles S. Harris	



11487

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynch		c. LENGTH OF STAY (in yrs) lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynch	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louis E. Kendall		4. DATE OF DEATH Oct. 16, 1961		5. AGE (In years last birthday) 42	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete plant laborer		9. KIND OF BUSINESS OR INDUSTRY Kent Co. Maryland		10. BIRTHPLACE (County & State, or foreign country) USA	
11. FATHER'S NAME Elwood P. Kendall		12. MOTHER'S MAIDEN NAME Daisy Sewell		13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW II	
14. SOCIAL SECURITY NO. 216-09-5208		15. INFORMANT Mrs. Anna U. Kendall		16. ADDRESS Lynch, Md.	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4-0-1 DUE TO (b) Probable coronary arteriosclerosis DUE TO (c) several yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 or 4 hrs.		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (Country) (State)	
25. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1961 to Oct. 16, 1961 , that (I) (we) last saw the deceased alive on Oct. 16, 1961 , and that death occurred at 8:30 PM from the causes and on the date stated above.		26. SIGNATURE Robert W. Farr		27. DATE 10/17/61	
28. PHYSICIAN'S NAME (Type) Robert W. Farr		29. ADDRESS Chestertown, Md.		30. REC'D BY REGISTRAR 10/17/61	
31. BURIAL, CREMATION, REMOVAL (Specify) Burial		32. DATE THEREOF 10/19/61		33. NAME OF CEMETERY OR CREMATORY Chestertown Cemetery	
34. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		35. ADDRESS Chestertown, Md.		36. REGISTRAR'S SIGNATURE Arthur S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11488

11473

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institut on, Residence before admiss on) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside Corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton	
c. LENGTH OF STAY IN IL 24 days		d. STREET ADDRESS ---	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print, First Middle Last) Glenn A. Liddell II		4. DATE OF DEATH Month 10 Day 10 Year 19 61	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/02
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Glen Liddell		14. MOTHER'S MAIDEN NAME Eva Bassett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) No		16. SOCIAL SECURITY NO. 086-16-6864 17. INFORMANT Eva C. Liddell, Betterton, Md. (wife) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary infarction, multiple DUE TO 7 201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Mural thrombi from acute myocardial DUE TO infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 mth		INTERVAL BETWEEN ONSET AND DEATH 1 mth	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that (I) (the) attending physician attended the deceased from 8-16-1961 to 10-10-1961 , that (I) (we) last saw the deceased alive on 10-9-1961 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Harry Paul Ross		22b. DATE SIGNED 10-10-61	
22c. PHYSICIAN'S NAME (Type) HARRY PAUL ROSS, M.D.		22d. ADDRESS 203 N. Queen St. Chestertown Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 10-12-61	
23c. NAME OF CEMETERY OR CREMATORY STILL POND CEMT Y		23d. LOCATION (City, town or county) (State) STILL POND MD	
24. FUNERAL DIRECTOR'S SIGNATURE Victor W. Kennedy		25a. REC'D BY REGISTRAR OCT 13 '61	
ADDRESS STILL POND, MD		25b. REGISTRAR'S SIGNATURE William S. Thomas	



TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11489

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11474

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown, RFD # 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne Hosp. (16 Hrs.)				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle Sappington Last				4. DATE OF DEATH Oct. 27, 1961 Month Day Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1884	
9. AGE (in years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY General Electric Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Sappington				14. MOTHER'S MAIDEN NAME Helen Mooney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 184-07-1701		17. INFORMANT Josephine Juchs 4215 Raymar Ave. Baltimore - 6 Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injuries including fractured skull DUE TO & contusions of brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) He was knocked down by an automobile sustaining DUE TO injuries noted above. Decompression was done at hosp. (c) about 6:00P.M.						INTERVAL BETWEEN ONSET AND DEATH 17 1/2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) see above			
20c. TIME OF INJURY Hour a. m. 9:30 p. m. 10/26/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Chestertown Kent Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/27/61	
EXAMINER'S NAME (Type) Robert W. Farr				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/61		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE 10/31/61	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

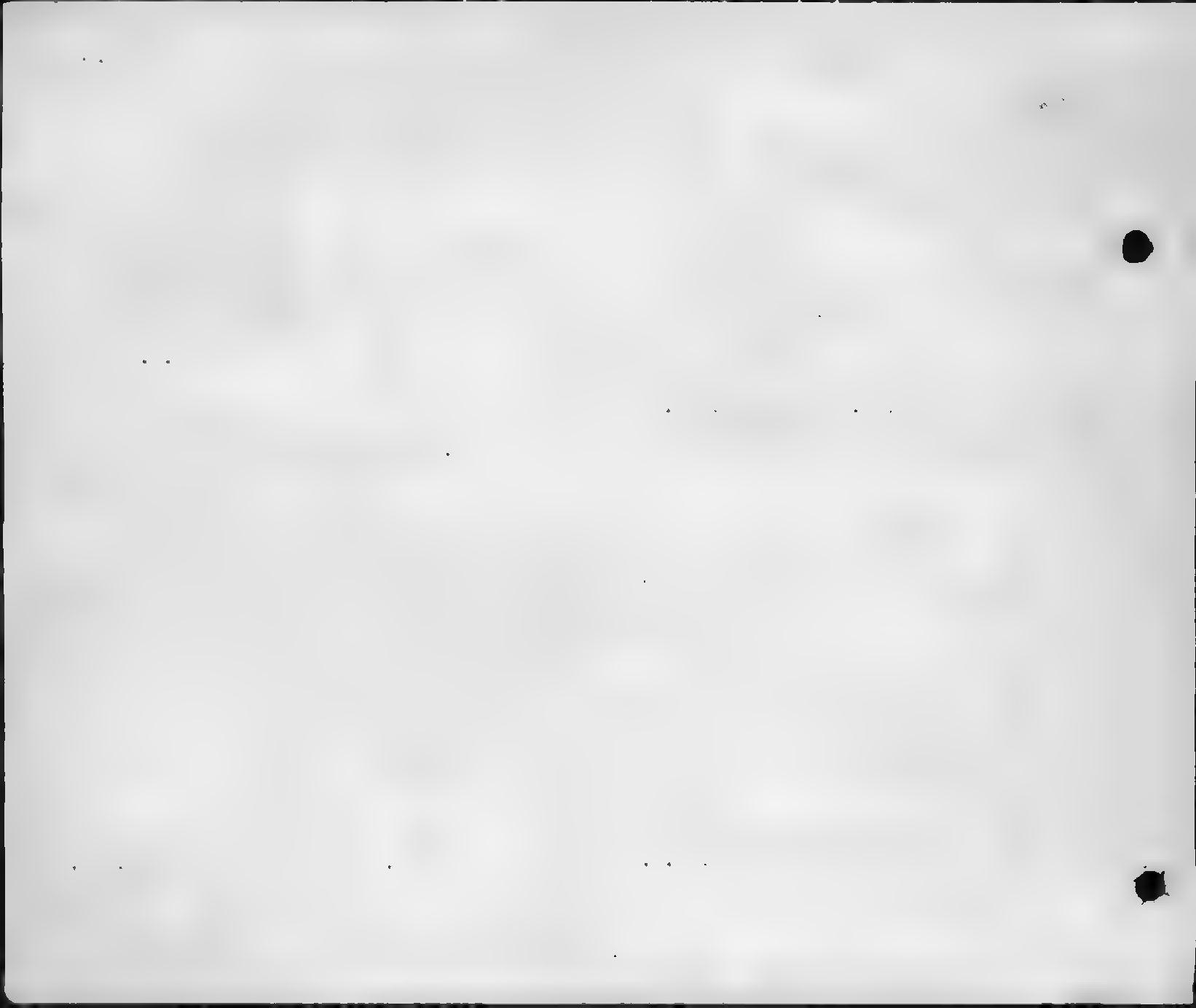
CERTIFICATE OF DEATH

11490

11475

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> c. LENGTH OF STAY IN 1b <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent & Queen Anne's Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS <u>1</u>							
3. NAME OF DECEASED (Type or print) <u>Robert Annians Shallcross</u>		4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>							
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9. AGE (In years last birthday) <u>80</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours M.n.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours M.n.	10. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months Days	Hours M.n.										
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Robert A. Shallcross, Sr.</u>							
14. MOTHER'S MAIDEN NAME <u>Kate Jones</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <u>218 34 8842</u>		17. INFORMANT <u>Robert A. Shallcross, Rock Hall, Maryland</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> (b) <u>Renal insufficiency</u> DUE TO (c) <u>Carcinoma of the bladder</u> </td> </tr> <tr> <td colspan="3"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Renal insufficiency</u> DUE TO (c) <u>Carcinoma of the bladder</u>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Renal insufficiency</u> DUE TO (c) <u>Carcinoma of the bladder</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20f. (City or town)</u> <u>(County)</u> <u>(State)</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>9-19</u> 1961, to <u>10-6</u> 1961, that (I) (we) last saw the deceased alive on <u>10-6</u> 1961, and that death occurred at <u>9:35 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Harry Paul Ross</u> M.D.				22b. DATE SIGNED <u>10-6-61</u>							
22c. PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS, M.D.</u>				22d. ADDRESS <u>203 N. Queen St, Chestertown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>							
23d. LOCATION (City, town or county) <u>Rock Hall</u>		23e. REC'D BY REGISTRAR <u>OCT 16 '61</u>		23f. REGISTRAR'S SIGNATURE <u>William L. Hume</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Eugene L. San Church Hill Md</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11491

11476

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE Maryland c. COUNTY Kent	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At Home		d. STREET ADDRESS Napley Green - Rock Hall	
3. NAME OF DECEASED (Type or print) Ruthwin I. Strong		4. DATE OF DEATH Month Oct. Day 20 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager of Farm		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Maryland	
13. FATHER'S NAME J. Edgar Strong		14. MOTHER'S MAIDEN NAME Rose Crouch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-34-9242	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Pulmonary Edema Cardio Vascular Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 20, 1961 to October 20, 1961 , that (I) (we) last saw the deceased alive on Oct 20, 1961 , and that death occurred at 11 PM , from the causes and on the date stated above.			
22a. SIGNATURE Norbert C. Nitsch		22b. DATE SIGNED 10/21/61	
22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch		22d. ADDRESS Rock Hall, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/61	
23c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.		23d. LOCATION (City, town or county) (State) near Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR DATE OCT 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL, OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed by the attending physician or hospital or attending physician. The law requires that the death certificate be executed by the attending physician or hospital or attending physician. The law requires that the death certificate be executed by the attending physician or hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Kent MARYLAND
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Chestertown
c. LENGTH OF STAY IN b. X Rock Hall
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent + Queen Annes'
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD b. COUNTY Kent
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
3. NAME OF DECEASED (Type or print) Tilghman First Last
4. DATE OF DEATH October 17 1961 Month Day Year
5. SEX MALE 6. COLOR OR RACE Negro 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Oct. 17-1961 9. AGE (in years, if under 1 year, last birthday) 10 yrs. 10 months 17 days 30 hours 30 min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. PLACE (County & State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Clarence Beck Sr 14. MOTHER'S MAIDEN NAME Dorothy Sarah Tilghman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address

18. CAUSE OF DEATH (Enter on y one cause per line for a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immaturity (10 weeks fetus)
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
DUE TO
(c), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH 15 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

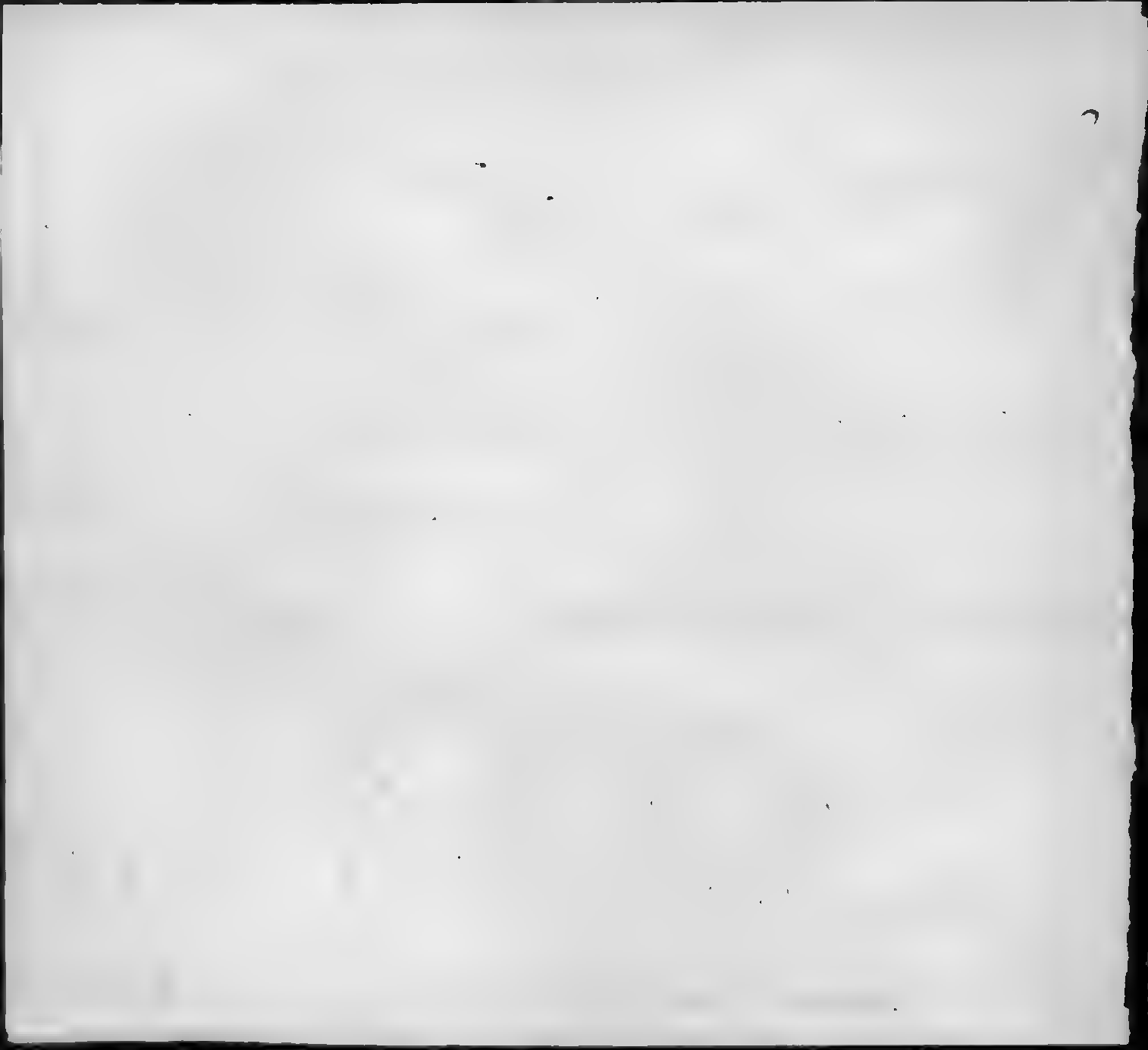
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 10-17 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (th's hospital) attended the deceased from 10-17 1961, to 10-17 1961, that (I) (we) last saw the deceased alive on 10-17 1961, and that death occurred at PM, from the causes and on the date stated above.

22a. SIGNATURE A.C. Dick M.D. 22b. DATE SIGNED 10-17-61
22c. PHYSICIAN'S NAME (Type) A.C. Dick 22d. ADDRESS Chestertown, Maryland
ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 10-17 23c. NAME OF CEMETERY OR CREMATORY Queen Anne's Hosp. 23d. LOCATION (City, town or county, (State)

24. FUNERAL DIRECTOR'S SIGNATURE K. W. Morin, Administrator ADDRESS 17 '62 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 10-17-61



11492

CERTIFICATE OF DEATH

Reg. Dist. No

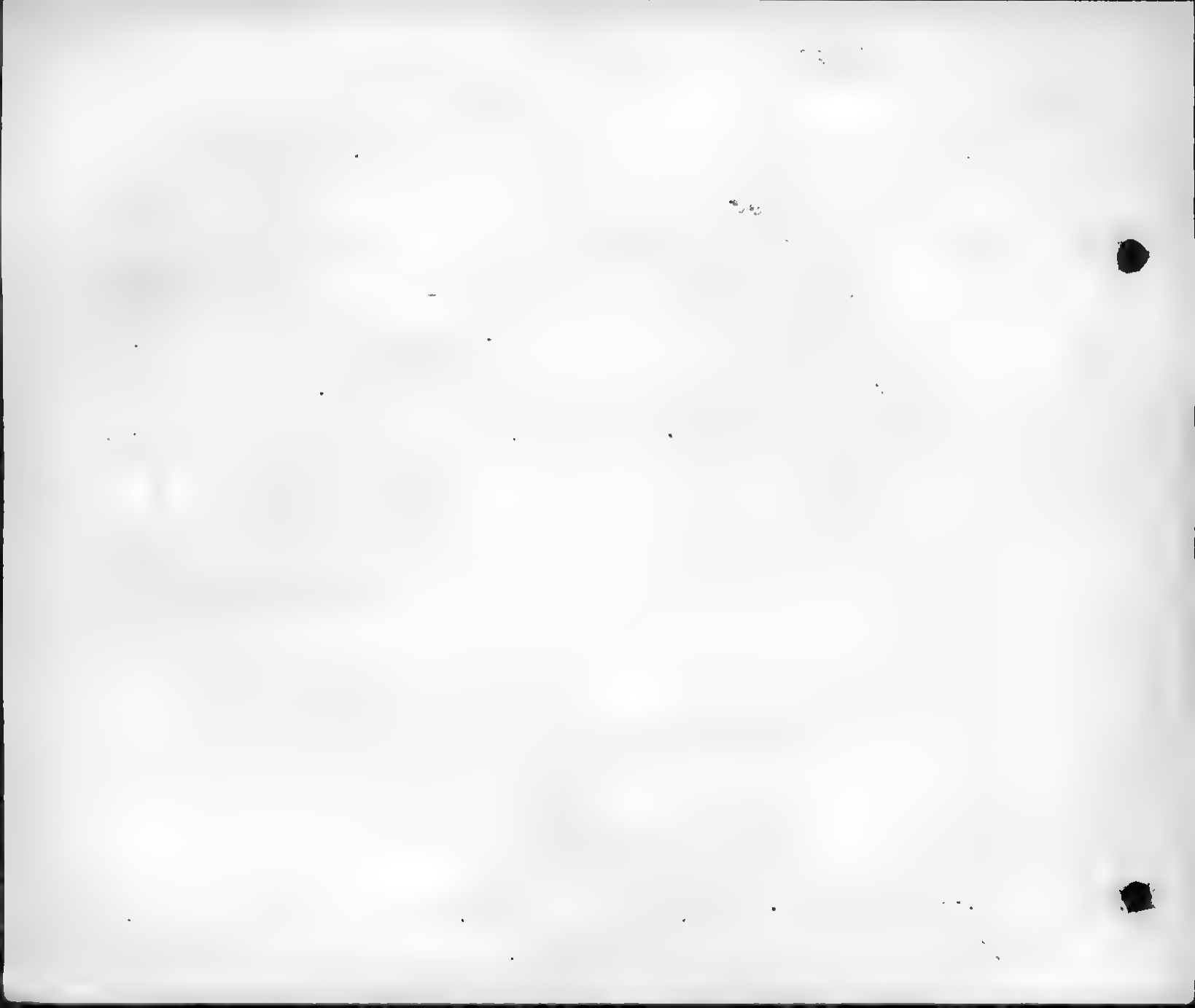
11477

1 PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rock Hall c. LENGTH OF STAY IN lb all d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rock Hall d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Michael First Wachowicz Middle Last 4 DATE OF DEATH Oct. 9 Month Day Year 19 61		5 SEX Male 6 COLOR OR RACE White 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11-1876 9 AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Poland	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Wachowicz		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-40-3616		INFORMANT Address Mrs. Anna Toulson--Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from Feb 1960 , 19 to Oct 9 , 19 61 , that I last saw the deceased alive on Oct 8 , 19 61 , and that death occurred at 12 noon from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall DATE SIGNED					
ACTUAL SIGNATURE E. Kester		M.D. Rock Hall			
PHYSICIAN'S NAME (Type) F. KESTER					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/61		22c. NAME OF CEMETERY OR CREMATORY St. John's Church	
22d. LOCATION (City, town, or county) (State) Rock Hall Md.					
23 FUNERAL DIRECTOR'S SIGNATURE Edgar J. Lane, Church Hill, Md.		ADDRESS		24a. REC'D BY REGISTRAR Oct 16 '61 24b. REGISTRAR'S SIGNATURE Charles S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



11493

CERTIFICATE OF DEATH

Reg. Dist. No. 11478

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton R.F.D.		c. LENGTH OF STAY IN 1b 27 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ross Middle Wiltbank Last Wiltbank		4. DATE OF DEATH Month October Day 20 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1904
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57	IF UNDER 24 HRS. Hours 57 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Samuel T. Wiltbank	
14. MOTHER'S MAIDEN NAME Hester Register		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 217-36-1364		INFORMANT Address Mary H. Wiltbank Worton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute right heart failure DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 1/2 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 61 , to October , 19 61 , that I last saw the deceased alive on October 20, 1961 , and that death occurred at 10:29 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Worton, Maryland DATE SIGNED 10-20-61			
ACTUAL SIGNATURE Florence Deringer Joyce M.D.		PHYSICIAN'S NAME (Type) Florence Deringer Joyce	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/61	
22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.	
24a. REC'D BY REGISTRAR OCT 23 '61		24b. REGISTRAR'S SIGNATURE Charles E. Kennedy	

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11494 Item 9 Film 0299 11/6/61 11479											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> c. LENGTH OF STAY IN 1b <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kentland Home Care</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Rural) Rock Hall</u> X d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>L</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 20 1871</u> <u>1908</u>		9. AGE (in years last birthday) IF UNDER 1 YEAR Months <u>9</u> Days <u>08</u> Hours <u>00</u> Min. <u>00</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Rock Hall, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Sanders</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Hospital Records</u> Address <u>Chestertown Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 9030 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Fracture neck of left femur</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>13 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. got up from chair + fell</u>							
20c. TIME OF INJURY Month, Day, Year <u>4:00</u> a.m. <u>10-16</u> 19 <u>61</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>(Rural) Rock Hall, Kent Md</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>10-16</u> 19 <u>61</u> to <u>10-28</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-28</u> 19 <u>61</u> , and that death occurred at <u>1:40</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Acc Sick</u> <u>A. C. Dick</u>				22b. DATE SIGNED <u>10-28-61</u>				22c. PHYSICIAN'S NAME (Type) <u>A. C. Dick</u>			
22d. ADDRESS <u>Chestertown, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>Oct. 30</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wesley CHAPEL</u>		23d. LOCATION (City, town or county) (State) <u>Rock Hall Ind.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar K. Lane - Church Hill, Ind.</u>				25a. REC'D BY REGISTRAR <u>NOV 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>					

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